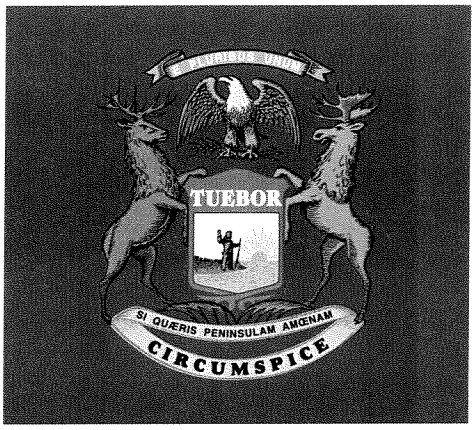
February 2005

Modernizing Michigan Medicaid



State of Michigan
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Michigan Medicaid: The Need for Change

The cost of operating the Michigan Medicaid program within the confines of its existing structure and the current state budget environment has become unsustainable. As Medicaid costs have climbed in recent years, Michigan revenues have steadily fallen (Figure 1). In order to adhere to the priority of protecting its most vulnerable citizens, Michigan is proposing a broad-base strategy that will permit the program to control costs while maintaining coverage for our vulnerable Michigan citizens.

Growth in Michigan Medicaid Change in Michigan Revenue

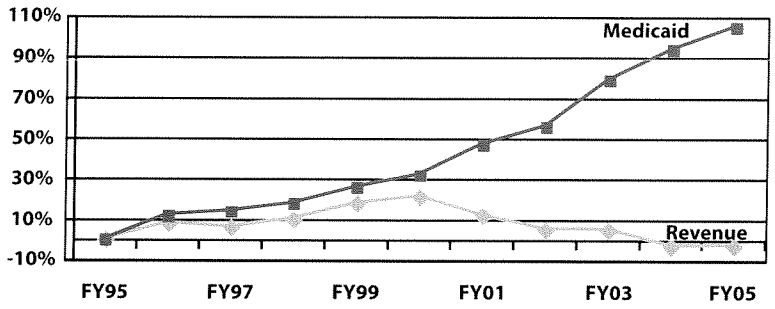

Figure 1 – The widening gap between Medicaid expenditures and revenue

> "In order to adhere to the priority of protecting its most vulnerable citizens, Michigan is proposing a broad-based strategy that will permit the program to control costs while maintaining coverage for our vulnerable Michigan citizens."

What is Medicaid?

The Medicaid program is a state-federal government partnership that provides health care benefits to low-income individuals who meet income and asset standards established in federal and state laws and regulations. Medicaid is financed based on a formula in which the federal government provides matching dollars for state funds. In return for federal funding, states must provide a mandated set of health care services, and may provide optional benefits to individuals meeting the eligibility requirements established for the program. In addition to requiring an established set of benefits, federal law also outlines specific groups of individuals that must be covered under Medicaid. States may also choose to cover optional populations meeting eligibility criteria for the program.

Growth of Medicaid

Similar to other states in the country, the Michigan Medicaid program has seen unprecedented growth in enrollment and expenditures over the last two years. Program costs have continued to mount despite aggressive initiatives targeted at cost control. For example, Michigan has been a leader in broad-scale managed care initiatives that are only now being expanded and touted in other states as a means to control Medicaid spending. No state Medicaid program has been more aggressive than Michigan in pursuing strategies aimed at reducing the skyrocketing costs associated with its pharmacy benefit. Figure 2 demonstrates the success Medicaid has had in controlling costs when compared with employer-sponsored benefit plans, and Figure 3 illustrates the effectiveness of Michigan's pharmacy cost containment efforts.

The Michigan Medicaid program has been able to hold the rate of growth in per beneficiary spending to a level far below commercial health insurers, however, caseload growth has increased total spending. As Figure 4 shows, the Medicaid caseload has grown virtually every month over the last four years and now stands at 1.4 million, well above the previous record of 1.2 million set in 1994. This caseload growth increased total spending in fiscal year 2004 to $7.1 billion, a $550 million increase over fiscal year 2003.

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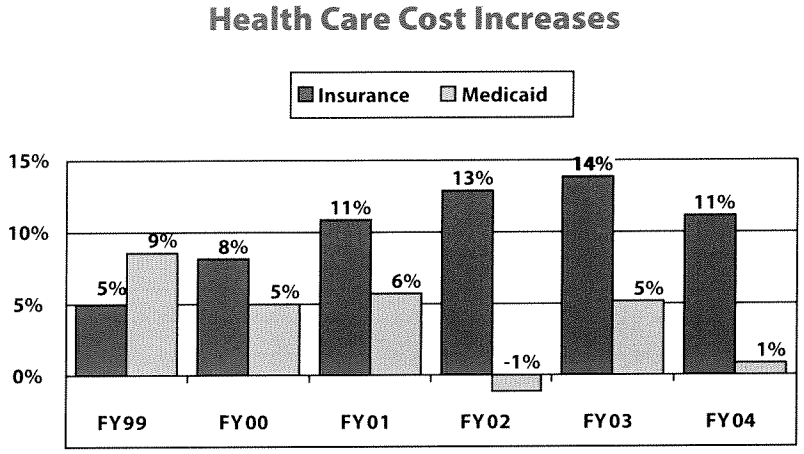

Figure 2 – Increases in Medicaid costs are lower than traditional private insurance

Spending growth, coupled with federal funding reductions, has forced Michigan to use a larger share of its discretionary resources to finance the program. Throughout the 1990s Michigan devoted less than 20 percent of its general fund revenue to Medicaid. In fiscal year 2004, Medicaid consumed 25 percent of general fund revenue (Figure 5). The percentage is anticipated to decline slightly to 23 percent in fiscal year 2005 because of the increased use of tobacco tax revenue as a financing source, but will start to grow again in future years unless new cost containment initiatives are implemented.

Also indicative of the strain that Medicaid places on the state budget, recent data show that Medicaid pays for nearly 40 percent of all births in Michigan, and two thirds of the individuals receiving long-term-care services. Program growth, coupled with state revenue constraints, has necessitated a close look at initiatives that will enable the state to sustain health care coverage for its most vulnerable populations, while stemming the growth of expenditures.

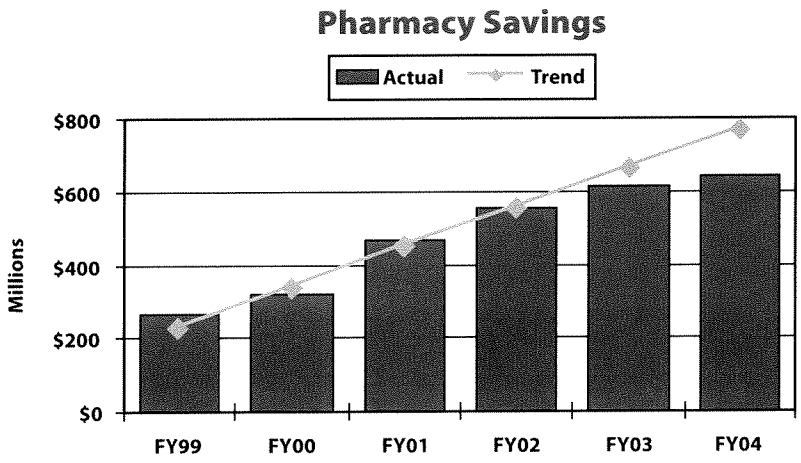

Figure 3 – Medicaid's proactive pharmacy cost-containment strategies work

"Michigan has been a leader in cost containment initiatives.

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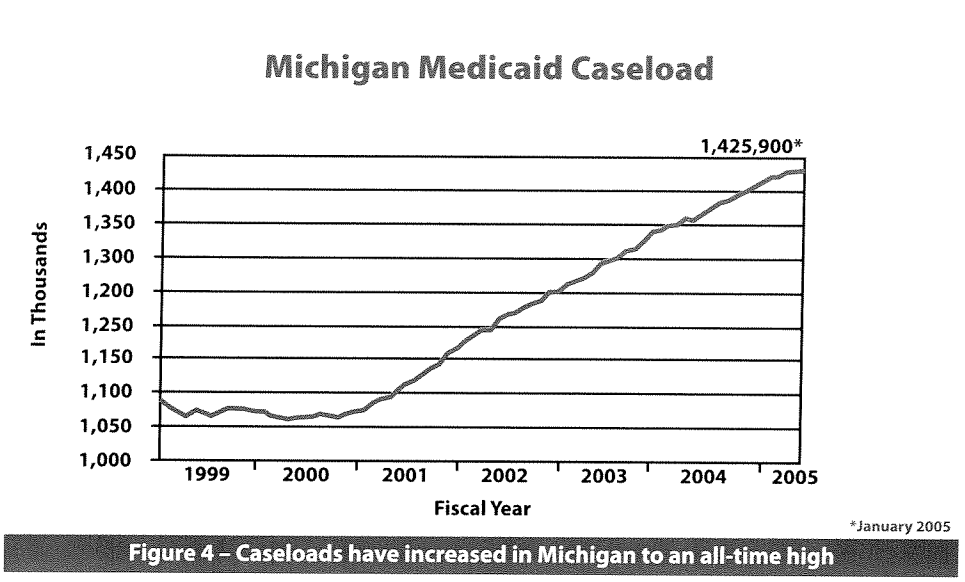

Figure 4 – Caseloads have increased in Michigan to an all-time high

"This caseload growth increased total spending in fiscal year 2004 to $7.1 billion, a $550 million increase over fiscal year 2003."

A Redesign with a Continued Commitment to Care

To accomplish the task of sustaining Medicaid coverage for those who need it most, the state proposes to redesign its Medicaid program in a manner that would offer some of the optional populations currently eligible for Medicaid a package of benefits equivalent to those offered through commercial insurance plans. In addition to a redefined benefit package, the state will also pursue additional opportunities that will allow the Michigan Medicaid program to sustain essential health care coverage for those who need it most.

Current Covered Benefits and Eligibles in Michigan

Benefits

The federal government mandates that states electing to participate in the Medicaid program offer a standard package of benefits to individuals who meet eligibility criteria that are established in federal law. In addition to the mandatory benefit package, states have the option of choosing from an array of optional benefits to provide to beneficiaries. The mandatory and optional benefits provided to Michigan Medicaid enrollees are outlined below.

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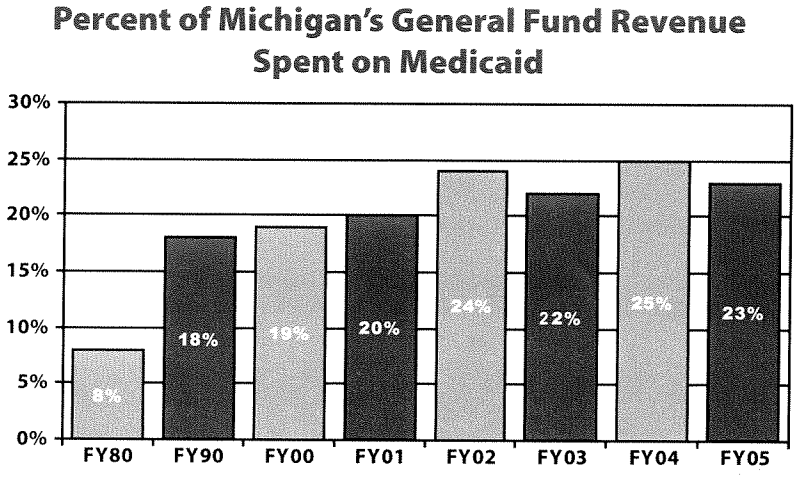

Figure 5 – Medicaid strain on state budget greater than ever

Eligibles

Federal law also defines the criteria under which individuals may become eligible to enroll in the Medicaid program. As explained below, eligibility requirements are defined for those who are categorically needy and those who are medically needy. Regardless of which specific eligibility group applies, Michigan remains committed to its most vulnerable populations and does not propose eliminating eligibility for any specific group.

The categorically needy group includes people whose eligibility is based primarily on income and assets. Included in this group are low-income families, children and pregnant women with limited assets, some of whom receive cash assistance. Aged, blind, or disabled individuals who receive Supplemental Security Income benefits are also considered to be categorically eligible. Federal law stipulates that coverage is mandatory for all of these groups.

Medically needy groups refer to those persons who meet the criteria for Medicaid coverage after deducting their incurred medical expenses. These are generally low-income individuals without other health insurance. States are not required to cover medically needy groups in their Medicaid programs, but if they elect to do so, federal law stipulates the specific groups that must be covered.

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Mandatory Benefits

- Inpatient Hospital Services
- Outpatient Hospital Services
- Physician Services
- Long-term-care services
- Diagnostic Services (Laboratory and X-ray)
- Rural Health Clinic Services
- Federally Qualified Health Center Services
- Nurse Midwife Services
- Certified Nurse Practitioner Services
- Home Health Services
- Family Planning Services
- Nursing Facility Services for over 21
- Physician Services and Medical/Dental services for a Dentist
- Early and Period Screening, Diagnostic, and Treatment Services for individuals under 21

Optional Benefits in Michigan

- Mental Health Services
- Prescribed Drugs
- Vision Services
- Hearing Services
- Physical and Occupational Therapies
- Private Duty Nursing
- Nurse Anesthetist Services
- Home Help/Personal Care
- Chiropractic Services
- Podiatry Services
- Prosthetic and Orthotic Services
- Optometry Services and Eyeglasses
- Speech, Hearing and Language Disorder Services

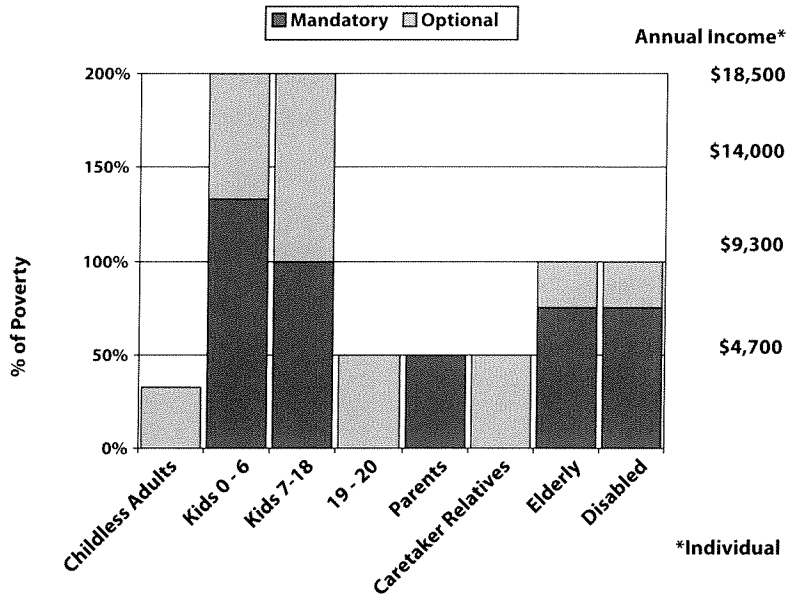

Figure 6 – Mandatory/Optional eligibility as compared to Federal Poverty Level

> "Medicaid pays for nearly 40 percent of all births in Michigan, and two thirds of the individuals receiving long-term-care services."

Because Michigan has elected to include the medically needy in its Medicaid program, coverage must be offered to medically needy pregnant women, medically needy children under age 18, newborns, and postpartum women. Michigan also has elected to provide coverage to medically needy groups that are considered optional under federal law. This optional population includes individuals under age 21 (19 and 20 year olds), caretaker relatives, aged, blind, or disabled individuals.

The Plan for Modernizing Michigan Medicaid

Michigan's plan for a sustainable Medicaid program relies on a balanced, multi-faceted approach. Rather than relying on changes affecting only a single aspect of the program, Michigan has devised a plan that contains costs while maintaining access to crucial health care services.

The state will pursue its reform initiatives through a combination of state plan amendments and a request to the federal government for approval to waive specific statutory requirements currently applicable to all state Medicaid programs.

Eligibility

Michigan remains committed to its most vulnerable populations currently receiving health care benefits through the Medicaid program. This means that Medicaid eligibility for children, pregnant women, and the elderly and disabled populations will remain unchanged. More importantly, no eligibility groups will be eliminated in FY '06.

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In order to sustain coverage and protect the most vulnerable, however, Michigan will seek approval from the federal government to effect a change in eligibility for healthy adults who receive Medicaid coverage. Currently non-pregnant, non-disabled adults receive Medicaid benefits in Michigan through one of the optional categories of coverage described previously. Under the Medicaid design for reform, the eligibility categories that provide coverage for adults who are 19 and 20 years of age will be subject to an enrollment freeze. Medicaid coverage for currently enrolled individuals in this group would continue, but new applicants would not be enrolled effective October 1, 2005. By freezing enrollment to sustain the program, the state would not need to eliminate entire categories of eligibility, and the program's current form can be retained/resumed in times of improved economic fortune.

Benefits

In its plan for Medicaid reform and sustainability, Michigan will offer a package of basic benefits that is on par with those provided through commercial health insurance carriers. This new benefit package will be offered to the optionally covered non-pregnant, non-disabled adults (caretaker relatives and 19 and 20 year-olds). A description of the revised benefit package follows.

- Select Optional Benefits: Michigan will revise the benefit package for non-pregnant, non-disabled adults. To be on par with commercial plans, payments for services such as hearing services, vision services, speech therapy, physical therapy, and occupational therapy will be the responsibility of the patient.
- Limitations on Covered Benefits and Cost Sharing: The state will also introduce limitations on some of the benefits it will continue to offer and introduce cost sharing for emergency room visits.
- Inpatient hospitalization will be limited to 20 days per year
- Prescription drug coverage will be limited to four prescriptions per month per beneficiary
- All emergency room visits will require a $10 co-payment

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Additional Reform and Sustainability Initiatives

Close Loopholes – Trusts and Annuities

Michigan will close loopholes that currently allow individuals and families to shield assets, including annuities and trusts that would otherwise be counted when determining an individual's eligibility for Medicaid. By shielding their assets, beneficiaries are able to avoid the use of their own resources to pay for long-term care and other medical services, thereby preserving the estate for their heirs by passing these costs on to the Medicaid program.

Estate Recovery

Subject to the passage of needed legislation, Michigan will implement a federally mandated estate recovery initiative. OBRA of 1993 requires state Medicaid programs to attempt to recover the costs of long term care services, excluding home and community-based services. OBRA also permits recovery of other medical expenses incurred during the decedent's long-term care episode. To date, Michigan has not implemented an estate recovery program; however, developing and implementing a humane program to recover costs from the estate of a deceased beneficiary will achieve significant savings.

Family Planning Waiver

Michigan has applied to the Centers for Medicare and Medicaid Services for a wavier that would allow the state to offer Medicaid family planning services to women of childbearing age, 19 through 44 years of age, who are not currently covered by Medicaid, do not have family planning benefits through private insurance, including Medicare, and who have family income at or below 185 percent of the FPL. Coverage would be limited to women who reside in Michigan and meet Medicaid citizenship requirements. It is estimated that at least 200,000 women may meet these criteria. Michigan will save significantly because the enhanced availability of a comprehensive family planning benefit supports an ongoing initiative within the state to reduce unintended pregnancies, and saves money by decreasing the number of Medicaid deliveries and related costs.

Retroactive Eligibility

Currently, federal law allows retroactive Medicaid eligibility for qualifying individuals up to three months prior to the month during which an application is filed. A waiver will be sought from the Centers for Medicare and Medicaid Services to eliminate retroactive eligibility, thereby permitting the state to only allow coverage beginning on the first day of the month of application.

Elimination of Chiropractic Care

Chiropractic care will be eliminated as a covered benefit for all beneficiaries of the Medicaid program.

Provider Assessments

In an effort to sustain coverage for the most vulnerable populations, the state is proposing new provider assessments for physicians and community mental health providers. The assessments will be similar to those currently levied against Medicaid HMOs, hospitals, and long term care providers. Consistent with the current assessments, funding generated will be primarily used to fund provider rate increases. Assessment funds will match federal dollars, which in-turn enables increased Medicaid reimbursement. These increased payments should also provide a meaningful incentive to improve access to primary health care and mental health services for Medicaid recipients.

Graduate Medical Education (GME)

Michigan has a strong culture of teaching hospitals, and the state has supported it generously. During this time, however, the state is unable to continue this support at current levels. A 4% reduction is being recommended so that this funding can be redirected to sustain eligibility for the current Medicaid population.

Rate Reductions

Providers are valued partners in the Medicaid program and during this extremely difficult budget year a 4% reduction in provider rates must be recommended in order to sustain support for current Medicaid eligibility groups. These reductions are necessary for the following Medicaid providers: hospitals, physicians, ambulances, laboratories, prosthesists/orthotists, home health providers, nursing homes, and health plans. Physician rate reductions would be restored if the physician quality assurance assessment discussed above is enacted.

Third Share Plans

A new strategy for shared financial responsibility for health care coverage will be introduced with the goal of expanding coverage to the currently uninsured. Under the Third Share Plan, employers, employees, and counties will each cover an equal portion of health care premiums for individuals enrolled in qualified health plans. The state will assist counties in meeting their share of the costs by providing them available federal Disproportionate Share Hospital (DSH) funds.

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Fiscal Implications

Current estimates indicate that the Michigan Medicaid Modernization and Sustainability Initiative described above could save the state general fund as much as $121 million in fiscal year 2006. The amount of savings that has been projected for individual components is presented below.

Michigan Medicaid Modernization and Sustainability Initiative Fiscal Year 2006 Savings

Category	Change/Initiative	Proposed Savings	
		General Fund	All Funds
Eligibility	Freeze enrollment for 19 and 20 year olds	($2,170,500)	($5,000,000)
	Eliminate 3 month retroactive eligibility	($12,285,000)	($28,300,000)
Benefits	Elimination of select optional benefits	($347,300)	($800,000)
	Annual limit of 20 inpatient hospital days for non-mandatory adult aid categories	($1,150,400)	($2,650,000)
	Prescription drug coverage limited to 4 scripts per month for non-mandatory adult aid categories	($1,063,500)	($2,450,000)
	ER co-pay of $10 for non-mandatory adult aid categories	($217,100)	($500,000)
	Eliminate chiropractic care for all beneficiaries	($600,000)	($1,382,200)
Sustainability Initiatives	Physician provider assessment	($40,000,000)	$124,395,700
	4% reduction in GME	($2,951,900)	($6,800,000)
	Provider rate reductions	($40,114,900)	($91,962,800)
	Third share plans	$0	$10,000,000
	Eliminate asset loopholes for trusts and annuities	($8,000,000)	($18,428,900)
	Family Planning Waiver	($7,800,000)	($6,550,000)
	Estate recovery	($4,341,000)	($10,000,000)
TOTAL GENERAL FUND SAVINGS		**($121,041,600)**	